CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

March 5, 2003

H.R. 877
Patient Safety Improvement Act of 2003

As ordered reported by the House Committee on Ways and Means on February 27, 2003

SUMMARY

H.R. 877 would expand the duties of the Center for Quality Improvement and Patient Safety (CQuIPS) within the Agency for Healthcare Research and Quality (AHRQ). CQuIPS would establish credentialing procedures for patient safety organizations (PSOs), which collect patient safety data voluntarily submitted by health care providers for inclusion in a patient safety database. The bill also would establish privacy protections and impose civil monetary penalties for violations of those protections.

In addition, H.R. 877 would establish the Medical Information Technology Advisory Board (MITAB), which would provide advice and recommendations on the compatibility of medical information technologies. The bill would require the Secretary of Health and Human Services, in consultation with the National Committee for Vital and Health Statistics and the MITAB, to develop voluntary national standards for uniform reporting of health care information.

CBO estimates that implementing H.R. 877 would cost $7 million in 2004 and $63 million over the 2004-2008 period. Nearly all of the costs of implementing H.R. 877 would be paid for by funds the Secretary of Health and Human Services would be required to transfer from the Federal Hospital Insurance (Medicare Part A) Trust Fund. Those costs, which CBO estimates would total $6 million in 2004 and $59 million over the 2004-2008 period, would be direct spending, because they would not be subject to the availability of appropriated funds. The bill would continue to affect direct spending after 2008; outlays during the following five years would total an estimated $71 million.

CBO estimates that discretionary spending for studies conducted by the General Accounting Office (GAO) would total $1 million in 2004 and $4 million over the 2004-2008 period, assuming appropriation of the necessary amounts. In addition, the bill could affect receipts,

as the federal government could collect fines from those found to be in violation of the privacy protections that would be established under the bill; CBO estimates that such effects would not be significant.

H.R. 877 would preempt any state freedom of information law that would require the disclosure of information provided by a health care provider to a certified patient safety organization. This preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would limit the application of those state laws. CBO estimates that this mandate would impose no requirement on states that would result in additional spending; thus, the threshold established by UMRA would not be exceeded ($59 million in 2003, adjusted annually for inflation).

H.R. 877 contains no private-sector mandates as defined in UMRA.

The bill defines health care providers for purposes of the legislation as providers of services within the Medicare program. Consequently, requirements that the bill would impose on health care providers would be conditions of participating in a voluntary federal program, and thus would not be mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 877 is shown in the following table. The costs of this legislation fall within budget functions 570 (Medicare) and 800 (general government).

	By Fiscal Year, in Millions of Dollars					
	2003	2004	2005	2006	2007	2008
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	14	14	14	14	14
Estimated Outlays	0	6	12	14	14	13
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	1	0	1	1	1
Estimated Outlays	0	1	0	1	1	1

Note: * = Less than $500,000.

BASIS OF ESTIMATE

Direct Spending

With the exception of the activities carried out by the GAO, funds for H.R. 877 would be transferred from the Federal Hospital Insurance Trust Fund and would not be subject to annual appropriation action. CBO estimates the bill would increase direct spending by $6 million in 2004 and $59 million over the 2004-2008 period.

H.R. 877 would expand the current duties of CQuIPS. The new duties would include the provision of technical assistance to states that have (or are developing) systems for reporting medical errors. CQuIPS also would provide for the certification and recertification of PSOs, which collect patient safety data from health care providers. (PSOs are private or public organizations that conduct activities to improve patient safety and the quality of health care delivery.) PSOs would not receive funding under this bill. In addition, CQuIPS would establish a patient safety database to collect, support, and coordinate the analysis of patient safety data that is reported on a voluntary basis. Based on information from AHRQ, CBO expects that these tasks would require increased staff for providing assistance to states, oversight of PSOs, and developing and maintaining the patient safety database. They would also require additional computer resources for the database. In 2004, we estimate that the direct spending would increase by $5 million, primarily for developing and maintaining the patient safety database. Outlays would rise to about $12 million a year after that, as AHRQ fully implements the certificate of PSOs, begins to recertify PSOs, and has a fully operational database on line. CBO estimates that direct spending would increase by $52 million over the 2004-2008 period, and by $121 million over the 2004-2013 period.

The bill would require the Secretary to develop and periodically update voluntary, national standards that promote the compatibility of health care information technology systems across all health care settings. CBO estimates that this effort would increase direct spending $2 million over the 2004-2008 period and by $4 million over the 2004-2013 period.

Finally, the bill would establish the Medical Information Technology Board (MITAB) to provide recommendations regarding medical information technology. The MITAB would terminate 30 days after the submission of its final report. For purposes of this estimate, CBO assumed that the MITAB would be created in October 2003, and therefore would terminate in April 2007. As stated in the bill, the MITAB would require one Executive Level V employee and support staff. In addition, while board members would not be compensated for their time serving on the MITAB, reimbursement for travel and per-diem expenses would be allowed. CBO estimates that the MITAB would cost $1 million in 2004 and $5 million over the 2004-2008 period.

Spending Subject to Appropriation

H.R. 877 would require the Comptroller General of the United States to provide to the Congress, within nine months of enactment, a survey of state laws that relate to peer review of patient safety data. Within five years after the date of enactment, the General Accounting Office would be required to submit the findings of a comprehensive evaluation of PSOs to assess the usefulness of the reported information, the level of adoption of error-reduction practices, and the overall effectiveness of the provisions of the bill in reducing medical errors. Assuming appropriation of the necessary amounts, CBO estimates that these tasks would cost the General Accounting Office $1 million in 2004 and $4 million over the 2004-2008 period.

Revenues

Because those convicted for violating the bill's privacy provisions could be subject to civil monetary penalties, the federal government might collect additional fines if the bill is enacted. Collections of civil fines are recorded in the budget as governmental receipts (revenues). CBO estimates that any additional receipts from such fines would be less than $500,000 a year.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS AND THE PRIVATE SECTOR

H.R. 877 would preempt any state freedom of information law that would require the disclosure of information provided by a health care provider to a certified patient safety organization. This preemption would be an intergovernmental mandate as defined in UMRA because it would limit the application of state laws. CBO estimates that this mandate would impose no requirement on states that would result in additional spending; thus, the threshold as established by UMRA would not be exceeded ($59 million in 2003, adjusted annually for inflation).

H.R. 877 contains no private-sector mandates as defined in UMRA.

The bill defines health care providers for purposes of the legislation as providers of services within the Medicare program. Consequently, requirements that the bill would impose on health care providers would be conditions of participating in a voluntary federal program, and thus would not be mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE:

On March 3, 2003, CBO transmitted a cost estimate for H.R. 663, the Patient Safety Quality Improvement Act, as ordered reported by the House Committee on Energy and Commerce on February 12, 2003. CBO estimated that implementing the provisions of that bill would increase discretionary spending by $104 million over five years. The difference in the estimate of outlays between H.R. 877 and H.R. 663 is largely due to the grant program for establishing an electronic prescription program authorized by H.R. 663. In addition, H.R. 877 would establish the MITAB and would require the GAO to conduct surveys and submit reports on patient safety activities.

Two bills also differ in how they are funded. H.R. 663 would amend the Public Health Service Act and authorize appropriations of discretionary spending. H.R. 877 would require the Secretary of Health and Human Services to transfer the necessary amounts to carry out all but the GAO activities in the bill from the Federal Hospital Insurance Trust Fund. Thus, $59 million of the $63 million cost of H.R. 877 would be direct spending.

H.R. 663 would require the inclusion of a unique product identifier on packaging of a drug or biological product that is subject to regulation by the FDA. This provision, which would be a private-sector mandate, is not included in H.R. 877. Unlike H.R. 877, the requirements of H.R. 663 would apply to all health care providers, not just those participating in Medicare. Consequently, the requirements of H.R. 663 would be mandates as defined in UMRA, rather than conditions of participation in a voluntary federal program.

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